ATTENDING PHYSICIAN'S STATEMENT

The patient is responsible for any expense incurred for completion of this form. This form should be completed by all relevant treating Physician's. Additional information may be requested upon evaluation.

Patient Name:

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Patient's Social Security Number: ______________________________

Patient's Date of Birth (mm/dd/yyyy): ______________________________

Date of Illness (first symptom) or Injury (accident) or Pregnancy (mm/dd/yyyy):

Date first seen and treated by you for this condition (mm/dd/yyyy):

Has patient had similar Illness or Injury? If yes, please give dates.

Date of disability (mm/dd/yyyy):

Date patient is expected to return to active work (mm/dd/yyyy):

Diagnosis or nature of Illness or Injury (please indicate primary and secondary).

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If disability is due to pregnancy, the expected delivery date is (mm/dd/yyyy): ______________________________

Actual delivery date is (mm/dd/yyyy): ______________________________

Procedures and/or Medical Services related to this disability:

mm/dd/yyyy	Description of Service	Type of Service	Diagnosis Code

Limitations:

What are patient's present capabilities?

What are patient's present limitations (physical and/or mental):

What restrictions, if any, are placed on patient?

Additional information or space needed:

Name and credential(s) of Treating Physician:

Physician's signature: Date:

Physician's contact information (name of practice, address, and phone number):

Please return to: National Benefit Administrators, Inc. PO BOX 690903, Charlotte, NC 28227
or fax to 704-844-2966

SHORT TERM DISABILITY EMPLOYEE REQUEST

This form should be completed when your disability absence exceeds the elimination period.
Please print clearly

Employee Name: ______________________ Social Security Number: ______________________

Address (street): ______________________ Birthdate: ______________________

Address (city/state/zip code): ______________________ Employee phone number: ______________________

Occupation / Job Title: ______________________ Annual Salary: ______________________

Is the absence work related? yes or no (circle)
Last day worked: ______________________

Is claim related to an accident? If Yes, please give details of accident (date, time, description, etc.)

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Nature of illness or injury for which claim is being made. If injury, please provide details of how, when, and where.

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Expected return to work date:

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Federal and State Income tax withholding information:
Applicable Federal and State withholdings will be withheld from benefit payments. Benefits paid and withholding information will be provided on the standard W-2, following the end of the Calendar Year.

I hereby give authorization for all providers of healthcare to release information concerning my condition(s), to National Benefit Administrators, Inc., for purposes of evaluation of my claim for disability benefits. A photocopy, scanned, or faxed copy will be deemed acceptable as the original signature authorization. I understand that if I knowingly give fraudulent information regarding my claim for disability, I can be prosecuted and held accountable to the fullest extent of the law.

Employee signature: ______________________ Date: ______________________

Print name: ______________________

Please return to: National Benefit Administrators, Inc. PO BOX 690903, Charlotte, NC 28227
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